UTAH MEDICAID NURSING FACILITY
State Fiscal Year 2009
QUALITY IMPROVEMENT INCENTIVE (3) APPLICATION
New Patient Lift System, Rule R414-504-4

This form and all supporting documentation must be received on or before June 8, 2009

Facility Name: _____

Medicaid Provider I.D. _____ Administrator: _____

Please mark all that are complete:

- ☐ This facility purchased, at a minimum:
  - ☐ One new normal duty patient lift capable of lifting patients weighing up to 450 pounds and one new heavy duty patient lift capable of lifting patients weighing up to 1,000 pounds; or
  - ☐ Two new heavy duty patient lifts capable of lifting patients weighing up to 1,000 pounds.
- ☐ A detailed description of the lifts purchased is attached.
- ☐ The patient lifts were purchased and installed on or after July 1, 2007, and no later than June 8, 2009.
- ☐ Proof of purchase that includes receipts and invoices, is also attached. This includes proof of payment, i.e. cancelled check(s), financial debt instrument, etc.

Qualifying facilities may receive up to $90 per Medicaid Certified bed (count as of 7/1/2008) under this incentive. Facilities will not receive more than was expended under this incentive.

Please ensure that all the supporting documentation is included. Failure to include all of the above detailed information will prevent the facility from qualifying.

By submitting this application I certify that all of the above criteria have been met.

Administrator Signature: _____ Date: _____

Note: Division staff will not request additional information relating to this submission. Please be sure to include all necessary information in order to qualify.